FORM
DP-156
811

NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINISTRATION

NURSING FACILITY QUALITY ASSESSMENT RETURN

Print and Reset Form

FOR DRA USE ONLY

Assessment Period Beginning _____ and ending _____ prepared in accordance with RSA 84-C:4

For Assessment Period: Check One ☐ January 1 - March 31 ☐ April 1 - June 30 ☐ July 1 - September 30 ☐ October 1 - December 31 ☐ 2008 ☐ 2009

STEP 1

NURSING FACILITY NAME

FEDERAL EMPLOYER IDENTIFICATION NUMBER

NUMBER AND STREET ADDRESS

ADDRESS (continued)

CITY/TOWN STATE & ZIP CODE

STEP 2 Return Type

Check the type of return ☐ INITIAL RETURN ☐ AMENDED RETURN ☐ FINAL RETURN LAST DAY OF BUSINESS _____ MO DAY YEAR

STEP 3 Figure Your Assessment

1 Net Patient Services Revenues 1

2 New Hampshire Nursing Facility Quality Assessment 2
[Line 1 x 5.5% (.055)]

STEP 4 Credits Interest and Penalties

3 Credits: (a) Payment made with extension..... 3(a)

(b) Credit carried over from prior period ..... 3(b)

(c) Original Return Payment ..... 3(c)
(Amended returns only)

TOTAL [Sum of Line 3(a) through Line 3 (c)] 3

4 BALANCE OF ASSESSMENT DUE (Line 2 less Line 3) 4

5 Additions

(a) Interest..... 5(a)

(b) Failure to Pay Penalty ..... 5(b)

(c) Failure to File Penalty..... 5(c)

5 TOTAL [Sum of Line 5(a) through Line 5(c)] 5

STEP 5 Balance Due

6 Balance Due (Line 4 plus Line 5) 6

STEP 6 For Amended Returns or Overpayment ONLY

NOTE: Do Not complete Step 6, Lines 7-10, unless you are filing an amended return.

7 Payments Made by Electronic Transfer 7

8 Adjusted BALANCE DUE [Line 6 minus Line 7]. Do not pay if less than $1.00 8
If a negative amount, enter zero and go to Line 9.

9 Overpayment..... 9
(Line 2 minus Line 3 plus Line 5, minus Line 7 if applicable)

10 Apply Overpayment to Credit on subsequent return payment..... 10

STEP 7 SIGNATURES

Under penalties of perjury, I declare that I have examined this return and to the best of my belief it is true, correct and complete. If prepared by a person other than the authorized Nursing Facility Representative, this declaration is based on all information of which the preparer has knowledge.

FOR DRA USE ONLY

Signature Of Officer (in ink) Date

Signature (in ink) of Paid Preparer Other Than Nursing Facility Representative

Print Signatory Name & Title

Preparer's Tax Identification Number Date

Preparer's Address

City/Town, State & Zip Code

MAIL TO:	NH DRA DOCUMENT PROCESSING DIVISION PO BOX 1004 CONCORD NH 03302-1004
and a COPY TO:	NH DEPT OF HEALTH & HUMAN SERVICES BUREAU OF ELDERLY & ADULT SERVICES RATE SETTING & AUDIT UNIT 129 PLEASANT STREET CONCORD NH 03301-3857

FORM
DP-156
INSTRUCTIONS

NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINISTRATION

NURSING FACILITY QUALITY ASSESSMENT RETURN

GENERAL INSTRUCTIONS

WHAT IS IT
Pursuant to RSA 84-C:2, there is an assessment of 5.5% of net patient services revenues on all nursing facilities on the basis of patient days in each nursing facility.

WHO PAYS IT
All nursing facilities in New Hampshire. Nursing facility means all nursing facilities licensed by the New Hampshire Department of Health and Human Services as defined by RSA 151-E:2,V, and facilities licensed as a specialty hospital and certified to receive federal reimbursement as a nursing facility.

WHEN IS THE RETURN DUE
Quarterly returns are due the 10th day of the month following the close of the assessment period, unless you have received an extension to file or payment plan approval from the Commissioner of Revenue Administration.

Period:	January 1	-	March 31	Due	April 10
Period:	April 1	-	June 30	Due	July 10
Period:	July 1	-	September 30	Due	October 10
Period:	October 1	-	December 31	Due	January 10

WHERE TO FILE THE RETURN
Completed returns shall be filed with:

NH Department of Revenue Administration
Document Processing Division
PO Box 1004
Concord, NH 03302-1004

And a copy shall be sent to:

NH Department of Health & Human Services
Bureau of Elderly & Adult Services
Rate Setting & Audit Unit
129 Pleasant Street
Concord, NH 03301-3857

WHEN TO MAKE PAYMENTS
Pursuant to RSA 84-C:3, payments shall be made electronically no later than the fifteenth day of the month following the assessment period. No penalty or interest will be assessed if payment is made on or before the last day of the month it is due. A completed Form DP-156-ACH must be submitted 30 days prior to the first return to facilitate the initiation of ACH Debit payments.

STEP 1 NAME & ID
Enter the Nursing Facility name, address, and federal employer identification number in the spaces provided.

STEP 2 RETURN TYPE
Please check whether this is an:- **Initial return** - First return ever filed by the facility; **Final return** - Last return to be filed by the facility and indicate last day of business; or **Amended return** - Used to report audit adjustments. Adjustments as a result of late notice of qualified beds should be reported as Prior Period Adjustments (P.P.A.) using NFQA Calculation worksheet.

STEP 3 ASSESSMENT
Line 1 Enter the net patient services revenue for the assessment period as defined by RSA 151-E:2,V.
Line 2 Enter your New Hampshire Nursing Facility Quality Assessment by multiplying Line 1 by .055.

STEP 4 CREDITS INTEREST PENALTIES
Line 3(a) Enter payments made with extension.
Line 3(b) Enter credit carried over from prior return, if applicable.
Line 3(c) If this is an amended return, enter the original return payments.
Line 3 Enter the sum of Lines 3(a), 3(b) and 3(c) on Line 3.

Line 4 Calculate the balance of Assessment Due - Line 2 less Line 3.

Lines 5(a) through 5(c)
Additions to assessment. Enter on Lines 5(a) through 5(c) any applicable interest and penalties for late payment or late filing. Calculate your interest and penalties, if any, as follows, and enter them on Lines 5(a) through 5(c).

Line 5(a) Interest: Interest is calculated on the balance of assessment due from the original due date to the date paid at the applicable rate listed below. Assessment due x number of days from due date to date tax was paid x daily rate decimal equivalent.

_____	_____	_____	_____	
Assessment Due	X Number of Days	X Daily Decimal Rate Equivalent	= Interest Due	

Enter on Line 5(a).

PERIOD	RATE	DAILY RATE DECIMAL EQUIVALENT
1/1/2009 - 12/31/2009	7%	.000192
1/1/2008 - 12/31/2008	10%	.000273
1/1/2007 - 12/31/2007	10%	.000274
1/1/2006 - 12/31/2006	8%	.000219
1/1/2005 - 12/31/2005	6%	.000164

Line 5(b) FAILURE TO PAY: A penalty equal to 10% of any nonpayment or underpayment of assessment shall be imposed if the taxpayer fails to pay the tax when due. If the failure to pay is due to fraud, the penalty shall be 50% of the amount of the non payment or underpayment.
Line 5(c) FAILURE TO FILE: A taxpayer failing to timely file a complete return may be subject to a penalty equal to 5% of the assessment due for each month or part thereof that the return remains unfiled or incomplete. The total amount of this penalty shall not exceed 25% of the balance of assessment due. Calculate this penalty starting from the original due date of the return until the date a complete return is filed.

Line 5 Enter the sum of Lines 5(a) through 5(c) on Line 5. If zero, enter 0.

STEP 5 BALANCE DUE
Line 6 Enter the balance of Line 4 plus Line 5. This represents the amount to be debited to your bank account 2 days prior to the last business day of the month, but not later than the last day of the month.

STEP 6 AMENDED RETURNS OR OVER PAYMENTS

NOTE: Do Not complete Step 6, Lines 7-10, unless you are filing an amended return.

Line 7 Enter payments made by electronic transfer.
Line 8 Enter the balance of Line 6 minus Line 7. If a negative amount, enter zero and go to Line 9. (File the return but do not pay if less than $1.00.)
Line 9 Overpayment - Line 2, minus Line 3, plus Line 5, minus Line 7 if applicable.
Line 10 Enter on Line 10 any overpayment you want credited to your next return, if applicable.

STEP 7 SIGNATURES
Original signatures (in ink) of Officer or authorized agent are required on all returns.

FORM
DP-156-ACH

NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINISTRA

Print and Reset Form

NURSING FACILITY QUALITY ASSESSMENT AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED PAYMENTS (ACH DEBITS)

STEP 1 FACILITY NAME & ADDRESS

NURSING FACILITY NAME

FEDERAL EMPLOYER IDENTIFICATION NUMBER

NUMBER AND STREET ADDRESS

ADDRESS (continued)

CITY/TOWN STATE & ZIP CODE

STEP 2 INITIAL, CHANGE, OR REVOCATION

Check the type of request:

☐ INITIAL REQUEST ☐ CHANGE REQUEST ☐ REVOKE AUTHORIZATION

STEP 3 DEPOSITORY INFORMATION

DEPOSITORY (BANK) INFORMATION

Depository (Bank) Name		Depository (Bank) Routing & Transit #	
Name on Depository Account		FEIN/SSN on Depository (Bank) Account	
Depository Account Number		Account Type (check one)	☐ Savings ☐ Checking

YOU MUST PROVIDE A COPY OF A VOIDED CHECK OR A SAVING WITHDRAWAL SLIP FOR THIS ACCOUNT.

STEP 4 ACH AUTHORIZATION

This authorization is to remain in full force and effect until the STATE has received written notice from me (or either of us) of its termination in such time and in such a manner as to afford the STATE and DEPOSITORY a reasonable opportunity to act on it.

By signing below, I hereby authorize the State of New Hampshire Treasury to initiate variable debit entries to the bank account and the depository named above.

PRIMARY NAME		TELEPHONE #
SECONDARY NAME		TELEPHONE #

STEP 5 SIGNATURES

By signing below, I hereby authorize the State of New Hampshire Treasury, to initiate debit entries to our Checking or Savings account indicated above at the depository (bank) named above, to debit the same to such account.

SIGNATURE (IN INK) OF AUTHORIZED OFFICER/REPRESENTATIVE

PRINT SIGNATORY NAME & TITLE

DATE

MAIL TO: NH DRA
DOCUMENT PROCESSING DIVISION
PO BOX 1004
CONCORD, NH 03302-1004

FOR DRA USE ONLY

FORM
DP-156-ACH
Instructions

NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINISTRATION

NURSING FACILITY QUALITY ASSESSMENT
AUTHORIZATION AGREEMENT FOR PRE-AUTHORIZED PAYMENTS (ACH DEBITS)

INSTRUCTIONS

WHO MUST FILE

All nursing facilities in New Hampshire. Nursing facility means all nursing facilities licensed by the New Hampshire Department of Health and Human Services as defined by RSA 151-E:2,V.

WHAT TO FILE

A completed DP-156-ACH and a copy of a voided check or savings withdrawal slip for this account.

WHEN TO FILE

ACH Debit authorization must be received by the New Hampshire Department of Revenue Administration (NH DRA) 30 days prior to (1) the first filing of Form DP-156, Nursing Facility Quality Assessment Return; (2) any time there is a request for change or revocation.

EFFECTIVE DATE OF ACH DEBIT

The ACH payment will be debited 2 days prior to the last business day of the month following the due date of the return or (if under extension or alternative payment agreement), on such date is approved by the Commissioner of Revenue Administration.

WHERE TO FILE

Completed authorization forms shall be filed with NH DRA for recording and then will be forwarded by the NH DRA to the NH Department of Treasury for processing.

REQUEST TO REVOKE AUTHORIZATION

All written debit authorizations must provide that the Receiver (Nursing Facility) may revoke the authorization only by notifying the Originator (NH DRA) in the manner specified in the Authorization. The Receiver (Nursing Facility) must be given a copy of their written debit authorization by the NH Treasury.

PRE-NOTE

An ACH Debit pre-note is required for the initial request and any changes.

LINE BY LINE INSTRUCTIONS

STEP 1

Enter the Nursing Facility name, address and Federal Employer Identification Number in the spaces provided.

STEP 2

Check the appropriate box to indicate whether this is an initial request, a change request, or a request to revoke ACH Debit Authorization.

STEP 3

Enter the Depository (Bank) information in the spaces provided. It is important to enter all digits of the routing and account number for accurate processing.

STEP 4

The Nursing Facility must provide a primary and a secondary name and telephone number for questions concerning ACH Debit Authorization. The facility shall file a change form whenever the primary or secondary contact person changes.

STEP 5

By signing, the authorized representative authorizes the NH Department of Treasury to debit their bank account by the amount reported to the NH Department of Revenue Administration on the Form DP-156.

Print and Reset Form

NEW HAMPSHIRE DEPARTMENT OF HEALTH & HUMAN SERVICES

NURSING FACILITY QUALITY ASSESSMENT CALCULATION WORKSHEET

(603) 271-4341

Facility Name:_____ FEIN:_____ License #:_____

Assessment Period Beginning _____ and ending _____ prepared in accordance with RSA 84-C:4

Check One: ☐ January 1 - March 31 ☐ April 1 - June 30 ☐ July 1 - September 30 ☐ October 1 - December 31

☐ 2008
☐ 2009
☐ Other _____

	PRIOR PERIOD ADJUSTMENTS SETTLED IN THIS PERIOD	CURRENT PERIOD	TOTAL
LINE 1 Medicaid Patient Net Revenues 1	(a)	(b)	(c)
LINE 2 Medicare Patient Net Revenue 2	(a)	(b)	(c)
LINE 3 All Other Patient Net Revenues 3	(a)	(b)	(c)
LINE 4 Total Patient Net Service Revenues ..... 4 (Nursing Facility Beds Only)	(a)	(b)	(c)
LINE 5 Medicaid Patient Bed Days..... 5	(a)	(b)	(c)
LINE 6 Medicare Patient Bed Days 6	(a)	(b)	(c)
LINE 7 All Other Patient Bed Days 7	(a)	(b)	(c)
LINE 8 Total Patient Bed Days..... 8	(a)	(b)	(c)

Prior period adjustments are not applicable to the initial filing period. Adjustments to previously filed assessment period's revenues are to be reflected as prior period adjustment in the period the change is settled.

Line 1 Medicaid Patient Net Revenues
Enter all Medicaid Patient Net Revenues on Line 1(b) and Line 1(c), including anticipated revenue for Medicaid residents including "Medicaid Pending" residents for services rendered for the assessment period.

LINE 2 Medicare Patient Net Revenue
Enter all Medicare Patient Net Revenue including any anticipated revenue for Medicare residents for services rendered for the assessment period.

LINE 3 All Other Patient Net Revenues
Enter All Other Patient Net Revenues including all anticipated revenue for all non-Medicaid and non-Medicare residents for services rendered for the assessment period.

LINE 4 Total Patient Net Service Revenues
Enter on Line 4(a) the sum of Lines 1(a) through Line 3(a) and repeat for (b) and (c). Enter all Total Patient Net Service Revenues for Nursing Facility Beds Only. Enter the amount from Line 4(c) NH Dept. of Revenue Form DP-156, Nursing Facility Assessment Return, Line 1.

LINE 5 Medicaid Patient Bed Days
Enter the actual occupied bed days of Medicaid residents including "Medicaid Pending" residents for services rendered during the assessment period.

LINE 6 Medicare Patient Bed Days
Enter the actual occupied bed days of Medicare residents for services rendered during the assessment period.

LINE 7 All Other Patient Bed Days
Enter the actual occupied bed days of all non-Medicaid and non-Medicare residents for services rendered during the assessment period.

LINE 8 Total patient Bed Days
Enter on Line 8(a) the sum of Lines 5 (a) through Line 7(a); Enter on Line 8(b) the sum of Lines 5(b) through 7(b); and Enter on Line 8(c) the sum of Lines 5(c) through 7(c). If zero, enter 0.

WHEN TO FILE
This calculation worksheet and a copy of the completed DP-156 shall be filed with Health and Human Services on or before the 10th day of the month following the close of the assessment period.

Mail This Worksheet To:	NH DEPARTMENT OF HEALTH & HUMAN SERVICES BUREAU OF ELDERLY & ADULT SERVICES 129 PLEASANT STREET CONCORD, NH 03301-3857

FORM
DP-156-PMT
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NEW HAMPSHIRE DEPARTMENT OF REVENUE ADMINIST

NURSING FACILITY RETURN PAYMENT

Print and Reset Form

For period beginning _____ and ending _____
Mo Day Year Mo Day Year

FOR DRA USE ONLY

PLEASE PRINT OR TYPE

Check One ☐ January 1 - March 31 ☐ April 1 - June 30 ☐ July 1 - September 30 ☐ October 1 - December 31 ☐ 2008 ☐ 2009

100% PAYMENT IS DUE ON OR BEFORE THE DUE DATE

NURSING FACILITY

FEDERAL EMPLOYER IDENTIFICATION NUMBER

NUMBER & STREET ADDRESS

ADDRESS (Continued)

CITY/TOWN, STATE & ZIP CODE

FOR DRA USE ONLY

1	Balance Due		1
	Additions		
2	Interest		2
3(a)	Failure to Pay	3(a)	
3(b)	Failure to File	3(b)	
3	Total Penalties (Line 3(a) plus Line 3(b))		3
4	Amount of This Payment (The sum of Lines 1, 2 and 3)		$

MAIL TO: NH DRA
DOCUMENT PROCESSING DIVISION
PO BOX 1004
CONCORD NH 03302-1004

PLEASE MAKE CHECK PAYABLE TO: STATE OF NEW HAMPSHIRE, ENCLOSE BUT DO NOT STAPLE OR TAPE, YOUR PAYMENT TO THIS FORM.

INSTRUCTIONS

WHEN DUE

Payments must be received by the statutory due date unless other provisions have been authorized by the Commissioner. Payments received beyond the prescribed due date are subject to interest and penalties in accordance with RSA 21-J.

INTEREST AND PENALTIES

NOTE: The interest rate is recomputed each year under the provisions of RSA 21-J:28, II. Applicable rates are as follows (contact the Department for applicable rates for any other years):

PERIOD	RATE	DAILY RATE DECIMAL EQUIVALENT
1/1/2009 - 12/31/2009	7%	.000192
1/1/200/ - 12/31/2008	10%	.000273
1/1/2007 - 12/31/2007	10%	.000274
1/1/2006 - 12/31/2006	8%	.000219
1/1/2005 - 12/31/2005	6%	.000164

FAILURE TO PAY: A penalty equal to 10% of any nonpayment or underpayment of taxes shall be imposed if the taxpayer fails to pay the tax when due. If the failure to pay is due to fraud, the penalty shall be 50% of the amount of the nonpayment or underpayment.

FAILURE TO FILE: A taxpayer failing to timely file a complete return may be subject to a penalty equal to 5% of the tax due for each month or part thereof that the return remains unfiled or incomplete. The total amount of this penalty shall not exceed 25% of the balance of tax due. Calculate this penalty starting from the original due date of the return until the date a complete return is filed.

NOTE: Taxpayers who substantially understate their tax may be assessed a penalty by the Department in the amount of 25% of any underpayment of the tax resulting from such understatement. There is a substantial understatement of tax if the amount of the understatement exceeds 10 percent of the tax required to be shown on the return or $5,000.

LINE-BY-LINE INSTRUCTIONS

Line 1 Enter the outstanding balance due from your Nursing Facility Quality Assessment.
Line 2 Enter the Interest due on Line 2.
Line 3(a) Enter the amount of Failure to Pay penalties, if applicable.
Line 3(b) Enter the amount of Failure to File penalties, if applicable.
Line 3 Enter the sum of Lines 3(a) and 3(b) on Line 3.
Line 4 Enter on Line 4, the amount of the payment being made by calculating the sum of Lines 1, 2 and 3.